FluWatch

Public Health Agency of Canada | Agence de la santé publique du Canada

15 to 28 June, 2014 (weeks 25 & 26)

Overall Summary

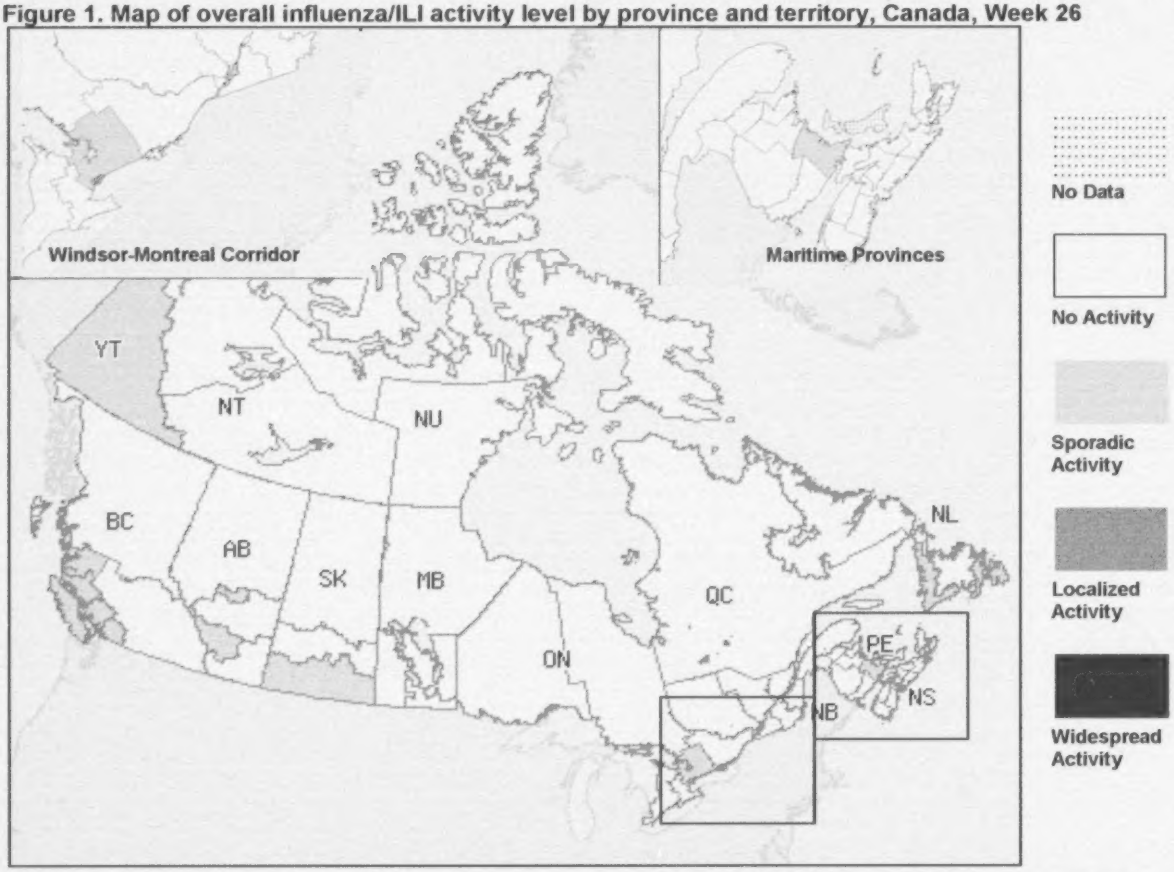
- In weeks 25 and 26, influenza activity in Canada continued to decline and is approaching inter-seasonal levels. Influenza B has circulated later into the spring than in previous seasons, but overall activity remains within expected levels. There have been no new influenza outbreaks reported in the last three weeks.
- As of week 26, 5,358 hospitalizations and 332 deaths have been reported from participating regions, which is slightly more hospitalizations but fewer deaths than were reported last year.

Are you a primary health care practitioner (General Practitioner, Nurse Practitioner or Registered Nurse) interested in becoming a FluWatch sentinel for the 2014-15 influenza season?
Contact us at FluWatch@phac-aspc.gc.ca

Influenza/ILI Activity (geographic spread)

In week 25, two regions in Ontario reported localized activity. In week 26, one of these regions continued to report localized activity (Figure 1). Eight regions did not report data in week 25 and one region did not report data in week 26.

Figure 1. Map of overall influenza/ILI activity level by province and territory, Canada, Week 26

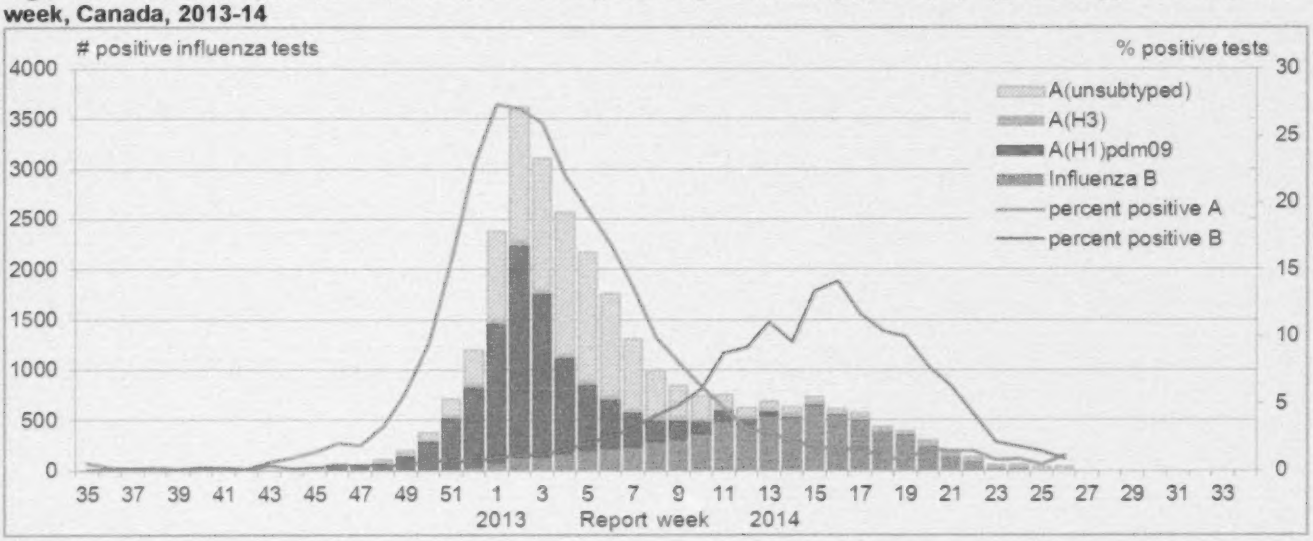


Note: Influenza/ILI activity levels, as represented on this map, are assigned and reported by Provincial and Territorial Ministries of Health, based on laboratory confirmations, sentinel ILI rates and reported outbreaks. Please refer to detailed definitions at the end of the report. Maps from previous weeks, including any retrospective updates, are available on the FluWatch website.

Influenza and Other Respiratory Virus Detections

The number of positive influenza tests continued to decline from 57 in week 24 to 35 in week 25, and remained stable at 35 (2.0% of tests) in week 26 (Figure 2). Influenza B declined in weeks 25 and 26, representing 46% of influenza detections. Most jurisdictions have reported low numbers of influenza detections in weeks 25 and 26 (Table 1). This season, A(H1N1)pdm09 predominantly affected adults 20-64 years of age and children <5 years of age, while influenza B affected greater proportions of adults ≥65 years of age and children 5-19 years of age (Table 2).

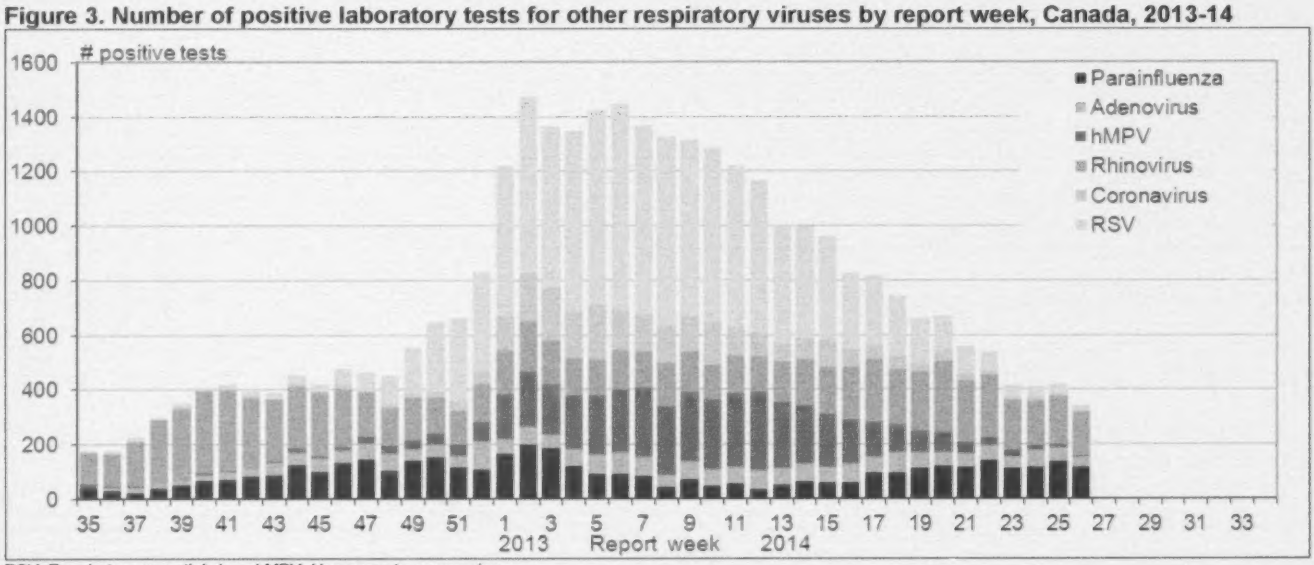
Figure 2. Number of positive influenza tests and percentage of tests positive, by type, subtype and report week, Canada, 2013-14



Detections of RSV, coronavirus, and human metapneumovirus have continued to decline and are approaching inter-seasonal levels. The number of positive tests for parainfluenza declined slightly in weeks 25 and 26, and detections of adenovirus have been stable over recent weeks, in keeping with the broader year-round circulation of these viruses. Detections of rhinovirus in recent weeks have been higher than during the same period over the past three seasons, however the number of positive tests decreased in weeks 25 and 26 (Figure 3).

For more details, see the weekly Respiratory Virus Detections in Canada Report.

Figure 3. Number of positive laboratory tests for other respiratory viruses by report week, Canada, 2013-14



RSV: Respiratory syncytial virus; hMPV: Human metapneumovirus

Table 1. Weekly and cumulative numbers of positive influenza specimens by type, subtype and province, Canada, 2013-14

Reporting provinces[1]	Two weeks (June 15 to 28, 2014)					Cumulative (August 25, 2013 to June 28, 2014)				
	Influenza A				B	Influenza A				B
	A Total	A(H1)pdm09	A(H3)	A(UnS)	B Total	A Total	A(H1)pdm09	A(H3)	A(UnS)	B Total
BC	6	0	0	6	10	1825	1614	67	144	384
AB	12	0	10	2	8	3899	3462	120	317	569
SK	0	0	0	0	2	1384	988	8	388	197
MB	0	0	0	0	0	685	463	7	215	72
ON	16	2	6	8	6	5826	2499	413	2914	3109
QC	2	0	0	2	2	5377	677	6	4694	2745
NB	0	0	0	0	4	1491	370	2	1119	130
NS	0	0	0	0	0	175	134	5	36	52
PE	0	0	0	0	0	119	118	0	1	5
NL	2	0	0	2	0	383	104	0	279	265
Canada	**38**	**2**	**16**	**20**	**32**	**21164**	**10429**	**628**	**10107**	**7528**
Percentage[2]	54.3%	5.3%	42.1%	52.6%	45.7%	73.8%	49.3%	3.0%	47.8%	26.2%

Table 2. Weekly and cumulative numbers of positive influenza specimens by type, subtype and age-group reported through case-based laboratory reporting[3], Canada, 2013-14

Age groups (years)	Two weeks (June 15 to 28, 2014)					Cumulative (August 25, 2013 to June 28, 2014)						
	Influenza A				B	Influenza A				B	Influenza A and B	
	A Total	A(H1) pdm09	A(H3)	A (UnS)	Total	A Total	A(H1) pdm09	A(H3)	A (UnS)	Total	#	%
<5	0	0	0	0	1	3270	1453	42	1775	558	3828	16.5%
5-19	1	0	0	1	2	1334	707	25	602	828	2162	9.3%
20-44	2	0	0	2	2	5107	2619	54	2234	1029	6136	26.4%
45-64	5	0	2	3	8	4486	2394	68	2024	1528	6014	25.9%
65+	14	1	10	3	7	2657	1002	179	1476	2279	4936	21.3%
Unknown	1	0	0	1	0	137	102	21	14	9	146	0.6%
Total	23	1	12	10	20	16991	8477	389	8125	6231	23222	100.0%
Percentage[2]	53.5%	4.3%	52.2%	43.5%	46.5%	73.2%	49.9%	2.3%	47.8%	26.8%		

[1] Specimens from NT, YT, and NU are sent to reference laboratories in other provinces. Cumulative data includes updates to previous weeks.
[2] Percentage of tests positive for sub-types of influenza A are a percentage of all influenza A detections.
[3] Table 2 includes specimens for which demographic information was reported. These represent a subset of all positive influenza cases reported.
UnS: unsubtyped: The specimen was typed as influenza A, but no result for subtyping was available.

Influenza Strain Characterizations

During the 2013-2014 influenza season, the National Microbiology Laboratory (NML) has antigenically characterized 2,358 influenza viruses [169 A(H3N2), 1,397 A(H1N1)pdm09 and 792 influenza B]. The vast majority (99%) of viruses were similar to the strains recommended by the WHO for the 2013-14 seasonal influenza vaccine. Two A(H1N1)pdm09 viruses showed reduced titres to antiserum against the reference A/California/07/2009 strain, and one A(H3N2) virus showed reduced titres to antiserum against the reference A/Texas/50/2012 strain. Twenty-eight influenza B viruses were similar to the strain recommended by the WHO for the 2011-12 vaccine (Figure 4).

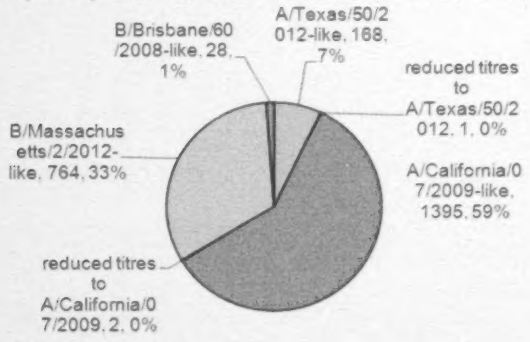

B/Brisbane/60/2008-like, 28, 1%
A/Texas/50/2012-like, 168, 7%
reduced titres to A/Texas/50/2012, 1, 0%
B/Massachusetts/2/2012-like, 764, 33%
A/California/07/2009-like, 1395, 59%
reduced titres to A/California/07/2009, 2, 0%

Figure 4. Influenza strain characterizations, Canada, 2013-14, N = 2,358

The NML receives a proportion of the number of influenza positive specimens from provincial laboratories for strain characterization and antiviral resistance testing. Characterization data reflect the results of haemagglutination inhibition (HAI) testing compared to the reference influenza strains recommended by WHO.

The recommended components for the 2013-2014 northern hemisphere trivalent influenza vaccine include: an A/California/7/2009(H1N1)pdm09-like virus, an A(H3N2) virus antigenically like the cell-propagated prototype virus A/Victoria/361/2011b (e.g. A/Texas/50/2012), and a B/Massachusetts/2/2012-like virus (Yamagata lineage).

Antiviral Resistance

During the 2013-2014 influenza season, NML has tested 2,302 influenza viruses for resistance to oseltamivir and all but five were sensitive. All 2,300 viruses tested for resistance to zanamivir were sensitive. All 1,647 influenza A viruses tested for amantadine resistance were resistant (Table 3).

Table 3. Antiviral resistance by influenza virus type and subtype, Canada, 2013-14

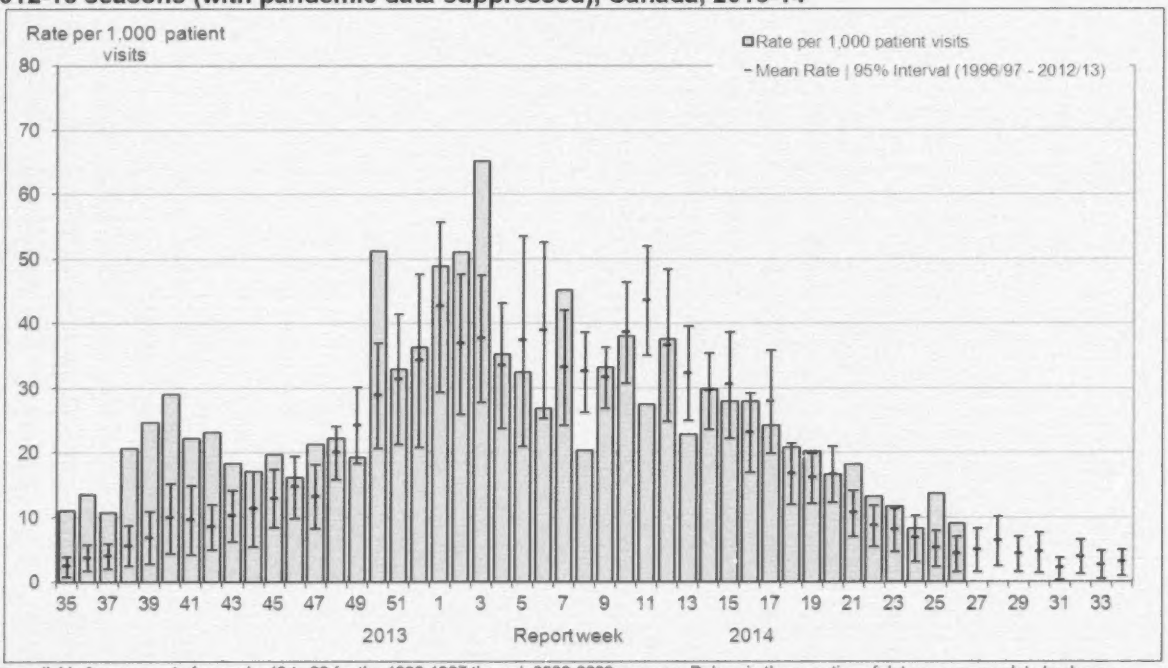
Virus type and subtype	Oseltamivir		Zanamivir		Amantadine	
	# tested	# resistant (%)	# tested	# resistant (%)	# tested	# resistant (%)
A (H3N2)	157	0	156	0	204	204 (100%)
A (H1N1)	1397	5 (0.4%)	1398	0	1443	1443 (100%)
B	748	0	746	0	NA[1]	NA[1]
TOTAL	2302	5 (0.2%)	2300	0	1647	1647 (100%)

[1] NA – not applicable

Influenza-like Illness Consultation Rate

The national influenza-like-illness (ILI) consultation rate increased from 8.2 consultations per 1,000 patient visits in week 24 to 13.7 per 1,000 in week 25. The rate decreased again in week 26 to 9.0 per 1,000. The rates for week 25 and 26 were above the expected range for this time of year (Figure 5).

Figure 5. Influenza-like-illness (ILI) consultation rates by report week, compared to the 1996-97 through to 2012-13 seasons (with pandemic data suppressed), Canada, 2013-14

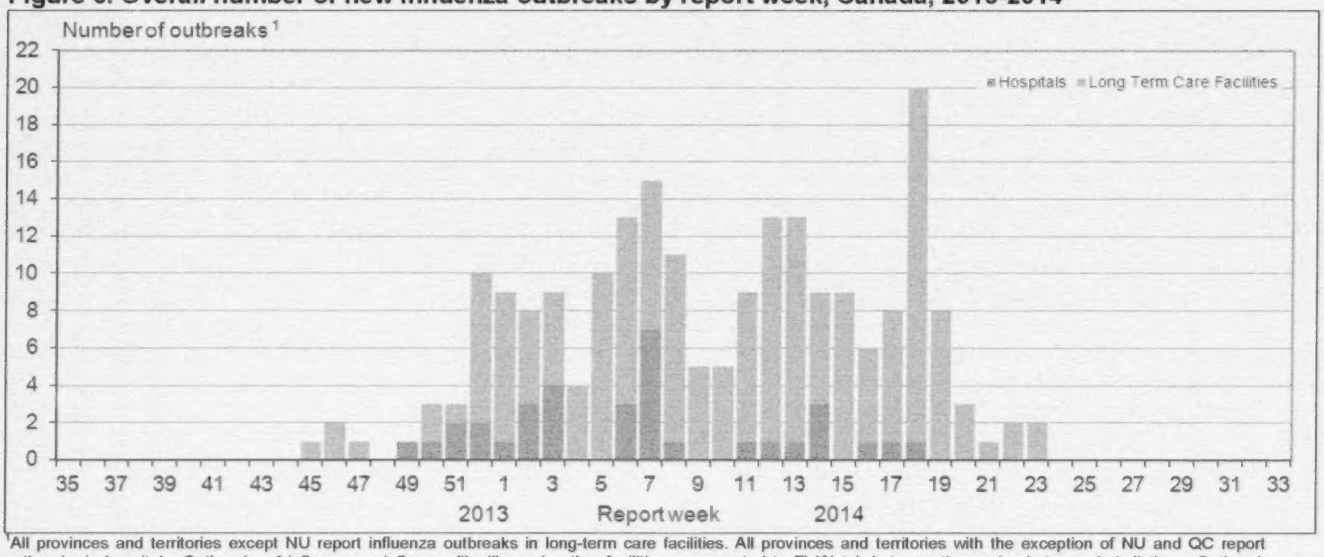


No data available for mean rate for weeks 19 to 39 for the 1996-1997 through 2002-2003 seasons. Delays in the reporting of data may cause data to change retrospectively. The calculation of the average ILI consultation rate over 17 seasons was aligned with influenza activity in each season. In BC, AB, and SK, data is compiled by a provincial sentinel surveillance program for reporting to FluWatch. The number of sentinel physicians in each province or territory is as follows: BC(21), AB(80), SK(11), MB(18), ON(169), QC(14), NB(29), NS(26), PE(4), NL(16), NU(1), NT(14), YT(13). Not all sentinel physicians report every week.

Influenza Outbreak Surveillance

No new influenza outbreaks were reported in weeks 25 and 26 (Figure 6).

Figure 6. Overall number of new influenza outbreaks by report week, Canada, 2013-2014

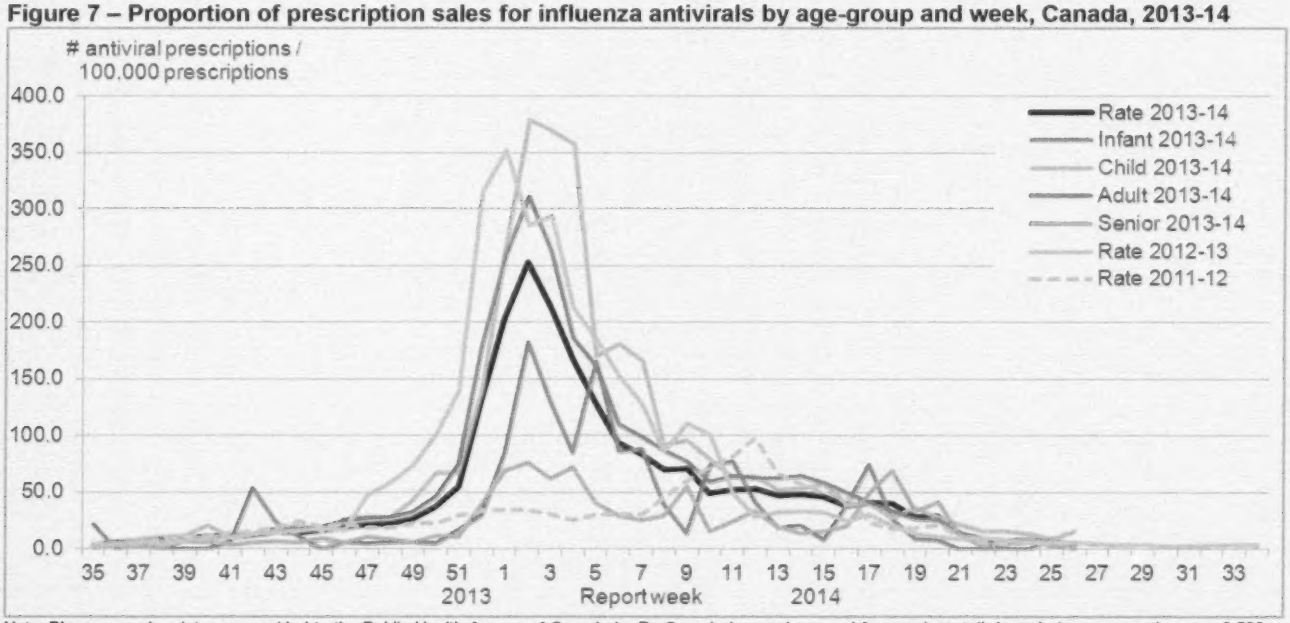


[1] All provinces and territories except NU report influenza outbreaks in long-term care facilities. All provinces and territories with the exception of NU and QC report outbreaks in hospitals. Outbreaks of influenza or influenza-like-illness in other facilities are reported to FluWatch but reporting varies between jurisdictions. Outbreak definitions are included at the end of the report.

Pharmacy Surveillance

In weeks 25 and 26, the proportion of prescriptions for antivirals continued to decline and is approaching inter-seasonal levels. Overall this season, the largest proportion of prescriptions for antivirals has been among children 2-18 years of age and adults 19-64 years of age (Figure 7).

Figure 7 – Proportion of prescription sales for influenza antivirals by age-group and week, Canada, 2013-14



Note: Pharmacy sales data are provided to the Public Health Agency of Canada by Rx Canada Inc. and sourced from major retail drug chains representing over 2,500 stores nationwide (excluding Nunavut) in 85% of Health Regions. Data provided include the number of new antiviral prescriptions (for Tamiflu and Relenza) and the total number of new prescriptions dispensed by Province/Territory and age group. Age-groups: Infant: 0-2y, Child: 2-18y; Adult: 19-64y, Senior: ≥65y

Sentinel Hospital Influenza Surveillance

Paediatric Influenza Hospitalizations and Deaths (IMPACT)

In weeks 25 and 26, no new laboratory-confirmed influenza-associated paediatric (≤16 years of age) hospitalizations, ICU admissions or deaths were reported by the Immunization Monitoring Program Active (IMPACT) network (Figure 8a).

To date this season, a total of 708 influenza-associated paediatric hospitalizations have been reported by the IMPACT network, 79% of which have been influenza A, and almost all of those subtyped (97%) were A(H1N1)pdm09. Children <5 years of age represent 73% of cases to date (Table 4). One hundred and twelve ICU admissions have been reported, of which 74 (66%) were children <5 years of age (Figure 9a). All but 19 were cases with influenza A, and 97% of those subtyped were A(H1N1)pdm09. Among the 98 ICU cases with available data, 71 (72%) were reported to have underlying medical conditions. One death has been reported this season. A smaller number of paediatric hospital admissions have been reported this year compared to the 2012-13 season.

Note: The number of hospitalizations reported through IMPACT represents a subset of all influenza-associated paediatric hospitalizations in Canada. Delays in the reporting of data may cause data to change retrospectively.

Adult Influenza Hospitalizations and Deaths (PCIRN)

Surveillance of laboratory-confirmed influenza-associated adult (≥16 years of age) hospitalizations by the PHAC/CIHR Influenza Research Network (PCIRN) Serious Outcomes Surveillance (SOS) network has ended for the 2013-14 season (Figure 8b). A summary of PCIRN-SOS data for the 2013-14 season will be included in the FluWatch annual report of influenza surveillance in Canada.

During passive and active surveillance* from August 25th, 2013 to May 31st, 2014, 1,985 influenza-associated hospitalizations were reported by the PCIRN-SOS network, 1,338 (67.4%) with influenza A, predominantly A(H1N1)pdm09 (Table 5). Compared to the 2012-13 season, slightly more cases were reported, although the peak number of cases was smaller. A greater number of cases were reported during March and April compared to last year, with six times more cases of influenza B reported. ICU admission was required for 321 hospitalizations, of which 263 were cases with influenza A (137 A(H1N1)pdm09, ten A(H3N2) and 116 A(unsubtyped)), 57 were cases with influenza B and the influenza type was not reported for one case. A greater proportion of cases were admitted to the ICU this season compared to last year, but the proportion of deaths was similar. Of the ICU admissions with available information, 85.9% (189/220) were reported to have at least one comorbidity, and 68.2% (176/258) reported not having been vaccinated this season. Among the 112 deaths reported this season, all but 28 were cases of influenza A (51 A(H1N1)pdm09, three A(H3N2) and 30 A(unsubtyped)); ten cases 20-44 years of age, 37 cases 45-64 years of age and 65 cases ≥65 years of age (Figure 9b). Among fatal cases with available information, 93.8% (60/64) were reported to have at least one comorbidity, and 48.2% (40/83) reported not having been vaccinated this season.

Note: During the 2013-14 influenza season, PCIRN-SOS conducted passive surveillance from August 25th to November 14th, 2013, and May 16th to 31st. Cases reported during this period were identified by laboratory detection of influenza among patients admitted to participating hospitals. Active surveillance was conducted between November 15th, 2013 and May 15th, 2014 during which time PCIRN site coordinators investigated cases potentially related to influenza. Data from both active and passive surveillance reported during the 2013-14 season are included in this report. The number of hospitalizations reported through PCIRN represents a subset of all influenza-associated adult hospitalizations in Canada. Delays in the reporting of data may cause data to change retrospectively.

Table 4 – Cumulative numbers of paediatric hospitalizations with influenza reported by the IMPACT network, Canada, 2013-14

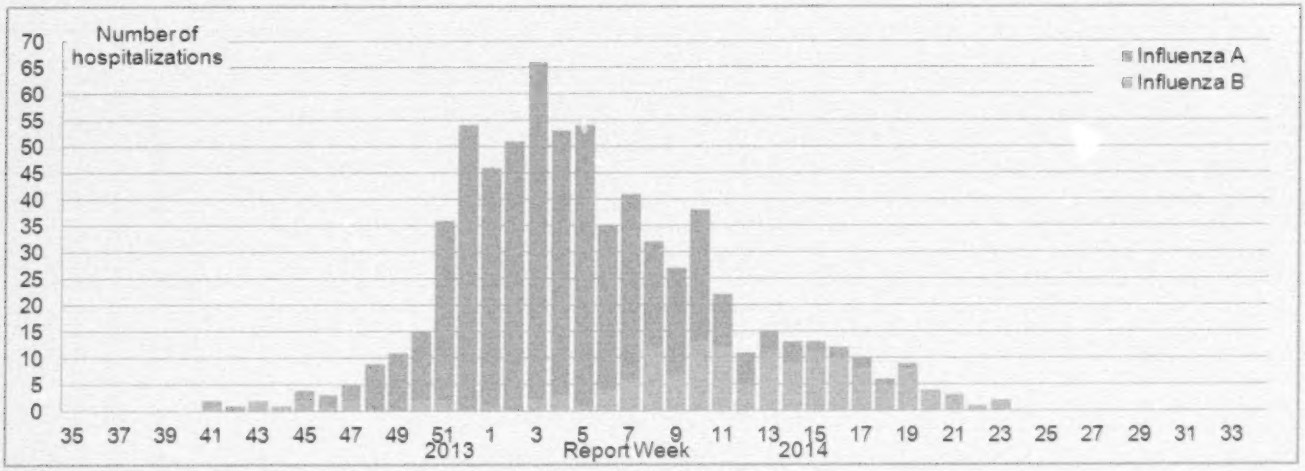
Age groups	Cumulative (25 Aug. 2013 to 28 June 2014)					
	Influenza A				B	Influenza A and B
	A Total	A(H1) pdm09	A(H3)	A (UnS)	Total	# (%)
0-5m	106	37	0	69	11	117 (17%)
6-23m	164	57	1	106	28	192 (27%)
2-4y	163	55	3	105	48	211 (30%)
5-9y	85	31	1	53	54	139 (20%)
10-16y	38	13	1	24	11	49 (7%)
Total	556	193	6	357	152	708
% [1]	78.5%	34.7%	1.1%	64.2%	21.5%	100.0%

Table 5 – Cumulative numbers of adult hospitalizations with influenza reported by the PCIRN-SOS network, Canada, 2013-14

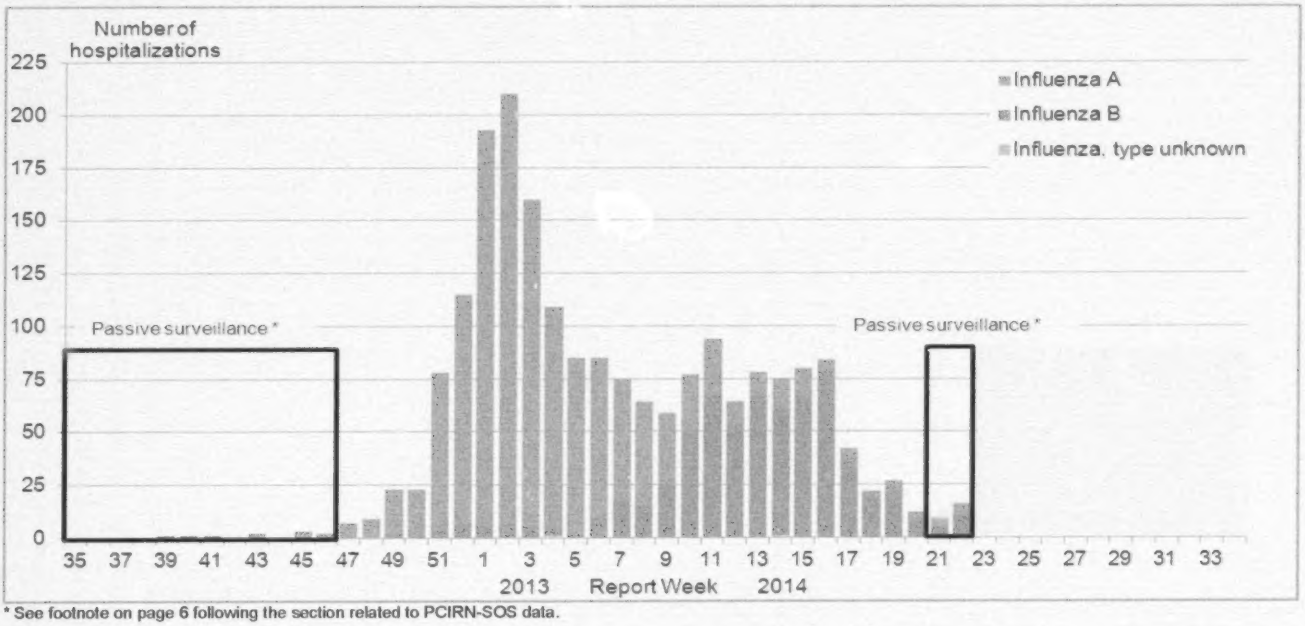
Age groups	Cumulative (25 Aug. 2013 to 28 June 2014)*					
	Influenza A				B	Influenza A and B
	A Total	A(H1) pdm09	A(H3)	A (UnS)	Total	# (%)
16-20	13	5	1	7	2	15 (1%)
20-44	276	142	7	127	47	323 (16%)
45-64	521	245	12	264	135	656 (33%)
65+	525	238	61	226	460	985 (50%)
Total	1 335	630	81	624	644	1 979
%	67%	47%	6%	47%	33%	100%

[1] Percentage of tests positive for sub-types of influenza A are a percentage of all influenza A detections. UnS: unsubtyped: The specimen was typed as influenza A, but no result for subtyping was available. * Two cases for which the influenza type has not yet been reported, and four cases for which the age-group was not reported, are not included in Table 5.

Figure 8 – Number of cases of influenza reported by sentinel hospital networks, by week, Canada, 2013-14
A) Paediatric hospitalizations (≤16 years of age, IMPACT)



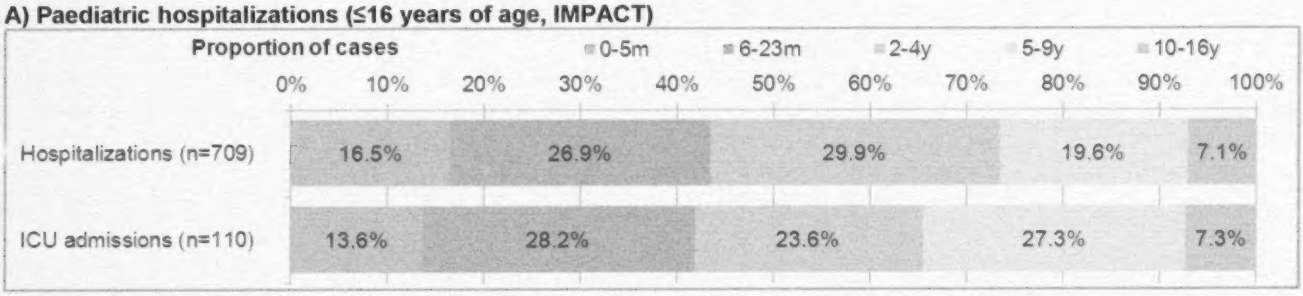
B) Adult hospitalizations (≥16 year of age, PCIRN-SOS)



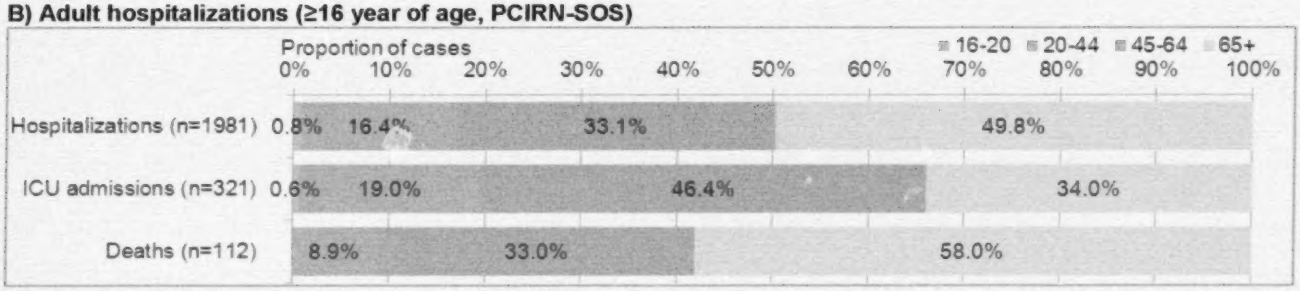
* See footnote on page 6 following the section related to PCIRN-SOS data.

Figure 9 – Percentage of hospitalizations, ICU admissions and deaths with influenza reported by age-group, Canada, 2013-14

A) Paediatric hospitalizations (≤16 years of age, IMPACT)



B) Adult hospitalizations (≥16 year of age, PCIRN-SOS)



Provincial/Territorial Influenza Hospitalizations and Deaths

In weeks 25 and 26, 55 laboratory-confirmed influenza-associated hospitalizations were reported from participating provinces and territories.* As with other surveillance indicators in weeks 25 and 26, the majority were cases of influenza B (44, 80.0%). There were no ICU admissions reported in weeks 25 & 26. Five deaths were reported: 1 adult 45-64 years of age, and 4 adults ≥65 years of age; 4 of the 5 with influenza B. The number of new influenza-associated hospitalizations and deaths reported for the current week may include cases from Ontario that occurred in previous weeks, as a result of retrospective updates to the cumulative total.

To date this season, 5,358 influenza-associated hospitalizations have been reported, 68.9% with influenza A. The majority (63.2%) of hospitalizations have been cases 45 years of age of older. A significantly greater proportion of cases of influenza B have been ≥65 years of age, and 5-14 years of age, compared to cases of A(H1N1)pdm09 this season (Table 6). A total of 380 ICU admissions have been reported this season, of which 63.9% were adults 20-64 years of age. A total of 332 deaths have been reported. The highest proportion of deaths has been among adults ≥65 years of age (56.0%) followed by adults 20-64 years of age (35.8%). In keeping with the late-season circulation, influenza B has been increasingly reported among hospitalized cases of influenza. To date this season, influenza B has been reported in 31.1% of hospitalizations and 34.6% of deaths. It is important to note that the hospitalization or death does not have to be attributable to influenza, a positive laboratory test is sufficient for reporting. Detailed clinical information (e.g. underlying medical conditions) is not known for these cases.

* Note: Influenza-associated hospitalizations are not reported to PHAC by the following Provinces and Territory: BC, NU, QC, and NB. Only hospitalizations that require intensive medical care are reported by Saskatchewan. ICU admissions are not distinguished among hospital admissions reported from Ontario. Data may also include cases reported by the IMPACT and PCIRN networks.

Table 6 – Cumulative number of hospitalizations with influenza reported by the participating provinces and territories, Canada, 2013-14

Age groups (years)	Cumulative (25 Aug. 2013 to 14 June 2014)					
	Influenza A				B	Influenza A and B
	A Total	A(H1) pdm09	A(H3)	A (UnS)	Total	# (%)
0-4	626	289	13	324	141	767 (14%)
5-14	136	65	6	65	121	257 (5%)
15-19	40	23	4	13	9	49 (1%)
20-44	623	425	9	189	104	727 (14%)
45-64	1133	711	34	388	307	1440 (27%)
65+	997	471	123	403	948	1945 (36%)
Unknown	138	99	3	36	35	173 (3%)
Total	3693	2083	192	1418	1665	5358
Percentage[1]	68.9%	56.4%	5.2%	38.4%	31.1%	100%

[1] Percentage of tests positive for sub-types of influenza A are a percentage of all influenza A detections.
UnS: unsubtyped: The specimen was typed as influenza A, but no result for subtyping was available.

See additional data on Reported Influenza Hospitalizations and Deaths in Canada: 2009-10 to 2013-14 on the Public Health Agency of Canada website.

Emerging Respiratory Pathogens

Human Avian Influenza

Influenza A(H7N9): Three new cases of human infection with influenza A(H7N9) have been reported by the World Health Organization since the last FluWatch report. Globally to July 3, 2014, the WHO has been informed of a total of 450 laboratory-confirmed human cases with avian influenza A(H7N9) virus, including 158 deaths.

Documents related to the public health risk of influenza A(H7N9), as well as guidance for health professionals and advice for the public is updated regularly on the following websites:
PHAC – Avian influenza A(H7N9)
WHO – Avian Influenza A(H7N9)

Middle East Respiratory Syndrome Coronavirus (MERS-CoV)

Despite recent increases in the number of cases and sporadic reports of cases exported outside the Middle East, the public health risk posed by MERS-CoV in Canada remains low (see the PHAC Assessment of Public Health Risk). Globally, from September 2012 to July 3, 2014, the WHO has been informed of a total of 826 laboratory-confirmed cases of infection with MERS-CoV, including 287 deaths. An additional 113 cases occurring between May 2013 and May 2014 reported by the Saudi Arabian Ministry of Health on 3 June 2014 are now reflected in the current case count. All cases have either occurred in the Middle East or have had direct links to a primary case infected in the Middle East.

Documents related to the public health risk of MERS-CoV, as well as guidance for health professionals and advice for the public is updated regularly on the following websites:
PHAC – Middle East respiratory syndrome coronavirus (MERS-CoV)
WHO – Coronavirus infections

International Influenza Reports

World Health Organization influenza update

World Health Organization FluNet

WHO Influenza at the human-animal interface

Centers for Disease Control and Prevention seasonal influenza report

EuroFlu weekly electronic bulletin

European Centre for Disease Prevention and Control - epidemiological data

South Africa Influenza surveillance report

New Zealand Public Health Surveillance

Australia Influenza Report

Pan-American Health Organization Influenza Situation Report

FluWatch Definitions for the 2013-2014 Season

Abbreviations: Newfoundland/Labrador (NL), Prince Edward Island (PE), New Brunswick (NB), Nova Scotia (NS), Quebec (QC), Ontario (ON), Manitoba (MB), Saskatchewan (SK), Alberta (AB), British Columbia (BC), Yukon (YT), Northwest Territories (NT), Nunavut (NU).

Influenza-like-illness (ILI): Acute onset of respiratory illness with fever and cough and with one or more of the following - sore throat, arthralgia, myalgia, or prostration which is likely due to influenza. In children under 5, gastrointestinal symptoms may also be present. In patients under 5 or 65 and older, fever may not be prominent.

ILI/Influenza outbreaks

- **Schools:** Greater than 10% absenteeism (or absenteeism that is higher (e.g. >5-10%) than expected level as determined by school or public health authority) which is likely due to ILI. Note: it is recommended that ILI school outbreaks be laboratory confirmed at the beginning of influenza season as it may be the first indication of community transmission in an area.
- **Hospitals and residential institutions:** two or more cases of ILI within a seven-day period, including at least one laboratory confirmed case. Institutional outbreaks should be reported within 24 hours of identification. Residential institutions include but not limited to long-term care facilities (LTCF) and prisons.
- **Workplace:** Greater than 10% absenteeism on any day which is most likely due to ILI.
- **Other settings:** two or more cases of ILI within a seven-day period, including at least one laboratory confirmed case; i.e. closed communities.

Note that reporting of outbreaks of influenza/ILI from different types of facilities differs between jurisdictions.

Influenza/ILI Activity Levels

1 = No activity: no laboratory-confirmed influenza detections in the reporting week, however, sporadically occurring ILI may be reported

2 = Sporadic: sporadically occurring ILI and lab confirmed influenza detection(s) with **no outbreaks** detected within the influenza surveillance region†

3 = Localized: (1) evidence of increased ILI* ;
(2) lab confirmed influenza detection(s);
(3) **outbreaks** in schools, hospitals, residential institutions and/or other types of facilities occurring in **less than 50% of the influenza surveillance region**†

4 = Widespread: (1) evidence of increased ILI*;
(2) lab confirmed influenza detection(s);
(3) **outbreaks** in schools, hospitals, residential institutions and/or other types of facilities occurring **in greater than or equal to 50% of the influenza surveillance region**†

Note: ILI data may be reported through sentinel physicians, emergency room visits or health line telephone calls.

* More than just sporadic as determined by the provincial/territorial epidemiologist.

† Influenza surveillance regions within the province or territory as defined by the provincial/territorial epidemiologist.

We would like to thank all the Fluwatch surveillance partners who are participating in this year's influenza surveillance program.

This report is available on the Public Health Agency website at the following address: http://www.phac-aspc.gc.ca/fluwatch/index.html.

Ce rapport est disponible dans les deux langues officielles.